Unannounced Medicines Management Inspection Report
7 September 2017

Moneymore

Type of Service: Nursing Home
Address: Cookstown Road, Moneymore, Magherafelt, BT45 7QF
Tel No: 028 8674 8118
Inspector: Rachel Lloyd

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 41 beds that provides care for patients living with a range of healthcare needs as detailed in section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** See below
Person in charge at the time of inspection: Mrs Ailish Devlin	**Date manager registered:** Mrs Ailish Devlin – acting, no application required
Categories of care: Nursing Homes (NH): NH-I – Old age not falling within any other category NH-PH – Physical disability other than sensory impairment Residential Care Homes (RC): RC-I – Old age not falling within any other category RC-PH(E) - Physical disability other than sensory impairment – over 65 years RC-MP(E) - Mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 41including: - a maximum of 4 residential places. - a maximum of 1 patient in category NH-PH

4.0 Inspection summary

An unannounced inspection took place on 7 September 2017 from 09.30 to 12.45.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the administration of medicines, the standard of record keeping and the storage of medicines.

The patient we spoke with was complimentary about the management of medicines and the care provided in the home.

No areas for improvement were identified.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patient experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Ailish Devlin, Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 13 June 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with one patient, two registered nurses and the manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives, visiting professionals and staff for completion and return to RQIA.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

Areas for improvements identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 13 June 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and was approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 10 May 2016

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13(4)

Stated: Second time</td><td>The registered manager must ensure that medicines are stored in locked cupboards at all times.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Medicines were stored in locked cupboards, trolleys and the refrigerator, outside of medicine administration times. No access to the treatment room was observed by staff other than the registered nurses on duty and the manager.</td></tr>
</table>

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	Procedures should be reviewed to ensure that Schedule 4 (Part 1) controlled drugs are denatured prior to disposal and that this is recorded in the record of disposal.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this had been addressed for most Schedule 4 (Part 1) controlled drugs disposed of. Staff were reminded that zopiclone must also be denatured. Assurances were provided that registered nurses would be reminded that this medicine must also be denatured prior to disposal in the future. For this reason this area for improvement was not stated for a second time.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in the management of medicines, PEG tubes, stoma appliances and swallowing difficulty was provided in the last year. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and organised. The manager advised that the proposed refit of the treatment room has still not taken place, but that it is hoped this will be completed soon. There were systems in place to alert staff of the expiry dates of most medicines with a limited shelf life, once opened. Two unlabelled and undated bottles of Calogen liquid in the refrigerator were removed for disposal. The manager advised that this would be discussed with registered nurses. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, supervision and appraisal, adult safeguarding, the management on medicines on admission/discharge and the storage of prescriptions.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. A care plan was not always maintained. The manager explained that

these medicines were under review for some patients. Care plans were completed during the inspection where necessary and the manager agreed to discuss this with registered nurses.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that most of the patients could verbalise pain and that a pain assessment tool was used as needed. A pain management care plan was maintained for most of the patients. For one patient without a care plan for pain management, this was addressed during the inspection. Staff also advised that a pain assessment is completed as part of the admission process.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Administration was recorded and care plans and speech and language assessment reports were in place.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the patient's health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of separate administration records for transdermal patches and some medicines prescribed on a 'when required' basis.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for many medicines which facilitated audit. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, the administration of medicines and audit procedures.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.

Throughout the inspection, it was evident that there was a good rapport between patients and staff. The staff treated the patients with respect and their approach was friendly and kind. They listened to the patients' requests.

The patient we met with spoke positively about the management of medicines and the care provided in the home.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

At the time of issuing this report, five questionnaires had been returned from patients and four from members of staff. The responses indicated satisfaction with all aspects of the care in relation to the management of medicines.

Areas of good practice

There was evidence that staff listened to patients and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Written policies and procedures for the management of medicines were in place. These were not examined. Management advised that these were reviewed regularly. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents. In relation to the

regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the manager, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any medicines related concerns were raised with management. They stated that there were good working relationships within the home and with healthcare professionals involved in patients' care.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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